National Jewish Health®
Morgridge Academy

Morgridge Academy
Mental Health Evaluation
303-398-1103

Student Name:_____ Age: _____ Today's Date: _____

Family Members Living in the Home

Name:	Age:	Gender:	Relationship to Student:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your student currently seeing someone for counseling? (circle one) YES or NO

→ If yes, who is their Mental Health Specialist (therapist/counselor, psychologist, psychiatrist, etc.):

Name	Reason for therapy
_____	_____

What is their current mental health diagnosis? _____

Is the student currently prescribed medications for their mental health diagnosis? (circle one) YES or NO

→ If yes, please list the name of the prescription(s) they are on, the dosage, and the prescribing physician:

_____
_____
_____

Mental Health Risk Factors (check all that apply):

____ witness to domestic violence	____ anxiety	____ low self-esteem/low confidence
____ grief/loss of loved one	____ sexual abuse	____ family conflict
____ parental divorce/separation	____ eating disorder	____ child abuse
____ loss of close friendship	____ traumatic event	____ school failure (held back)
____ mental health hospitalization	____ poverty	____ single parent home
____ self-harm	____ rebelliousness	____ poor social skills

Anything else related to your child's mental health that you think we should be aware of? _____

_____
_____

Parent/Guardian Name: _____ Signature: _____